LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) APPLICATION FOR ASSISTANCE

♦ Application is not complete without applicant signature on page 2.

For Agency Office Use Only
DATE RECEIVED:

Type of assistance you are applying for: (Check one)
_____ Energy Assistance _____ Crisis Assistance

Have you received assistance under the LIHEAP program
since July 1 of this year through any TN LIHEAP Agency? Yes No (circle)

If yes, which agency provided assistance? _____

Applicant Name:			Telephone: Cell:	
Current Address:	City:	State:	Zip:	How long at this location?
County:				
Mailing Address:	City:	State:	Zip:	
Previous Address:	City:	State:	Zip:	How long at this location?

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT). USE BLANK SHEET IF YOU NEED MORE SPACE

Name	Relationship to Applicant	Social Security #	D.O.B.	Age	Sex	Race	Education Level	Receive Food stamps?	Disabled	Health Insurance	Income	Source of Income	Gross Monthly Income
Applicant Name:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		
Household Member:								Y or N	Y or N	Y or N	Y or N		

~NOTE: Assistance will be denied due to an applicant's refusal or inability to furnish all household members' Social Security Numbers and Verification.

►YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD AGE 18 OR OLDER ◄

FAMILY TYPE (check one)	
Single Parent Female	
Single Parent Male	
Two Parent Household	
Single Person	
Two Adults NO Children	
Other	

Total Annual Gross Income All Household Members Over Age 18
$

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DO YOU HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? Y or N

DOES YOUR HOUSEHOLD RECEIVE REGULAR FINANCIAL ASSISTANCE FOR DISABILITY? Y or N

PLEASE STATE DISABILITY: _____
(documentation not required)

HOUSING: (Please circle one) ⌂ OWN ⌂ RENT ⌂ SECTION 8 ⌂ PUBLIC HOUSING AUTHORITY

SOURCE(s) OF ENERGY: (Circle)

Wood	Electric	Fuel Oil
Coal	Kerosene	
Natural Gas	L.P. Gas	

PUBLIC HOUSING/SECTION 8 TENANTS ONLY

Amount of Utility "Overage" $_____

HOME ENERGY COSTS: **$** _____

UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:

Utility Company Name: _____

Utility Company Address: _____

Phone #: _____

Account #: _____

UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:

Utility Company Name: _____

Utility Company Address: _____

Phone #: _____

Account #: _____

IF APPLYING FOR "CRISIS" ASSISTANCE, TELL US WHY?

Has your electric or gas been disconnected? Y or N

Have you received a cut off notice? Y or N

***If you have received a cut off notice, please attach a copy.**

(PLEASE ATTACH STUBS, INVOICES, RECEIPTS, ETC FOR ALL ENERGY SOURCES IN THE HOUSEHOLD)

I CERTIFY THAT THE ABOVE ACCOUNT(S) IN THE NAME OF _____

IS FOR THE USE OF MY HOUSEHOLD AND I AM RESPONSIBLE FOR ITS PAYMENTS.

IS THIS ACCOUNT IN YOUR LANDLORD'S NAME? Y or N

Has your home ever been served under our Weatherization Assistance Program? Y or N

Are you interested in that program? Y or N

Applicant Certification:

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT ALL OF THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT. I ALSO AUTHORIZE THE VERIFICATION OF ANY AND ALL INFORMATION FOR THE PURPOSE OF CERTIFICATION AND FOR ASSISTANCE, AND DO____ OR DO NOT ____ AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES. I UNDERSTAND THAT ANYONE WHO FRAUDULENTLY COVERS UP A MATERIAL FACT OR WHO KNOWINGLY GIVES FALSE INFORMATION REQUIRED FOR ELIGIBILITY DETERMINATION IS LIABLE TO PROSECUTION UNDER APPLICABLE CRIMINAL LAWS. I ALSO CERTIFY THAT I HAVE BEEN INFORMED OF THE APPEAL PROCESS UNDER PROVISIONS OF THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM AND THAT I SHALL BE NOTIFIED OF MY ELIGIBILITY STATUS WITHIN THE TIME PERIOD ACKNOWLEDGED TO ME BY THE AUTHORIZED PERSONNEL OF THE LOCAL CONTRACT AGENCY.

APPLICANT SIGNATURE: _____

NO PERSON ON THE BASIS OF HANDICAP, RACE, COLOR, RELIGION, SEX, AGE OR NATIONAL ORIGIN WILL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN THE OPERATION OF THE LIHEAP PROGRAM.

To Be Completed By Agency Staff Only:

Number of Household Members Who Are:	
Age under 12 months	_____
Age 2 years or under	_____
Age 3-5 years	_____
Age 60-69 years	_____
Age 70 or older	_____

*ELIGIBLE BENEFIT LEVEL $*_____ *AUTHORIZED AGENCY OFFICIAL:* _____ *DATE/TIME TAKEN:* _____

VOUCHER #: _____ *DATE/TIME CALLED INTO VENDOR* _____

% OF POVERTY _____ *% OF ENERGY BURDEN* _____ *TOTAL POINTS* _____

SIGNATURE OF REVIEWER: _____ *DATE CERTIFIED* _____